Department of Behavioral Healthcare, Developmental Disabilities and Hospitals
Office of Facilities and Program Standards and Licensure
14 Harrington Road, Cranston, Rhode Island 02920
Phone: 462-6049 Fax: 462-0393

APPLICATION FOR LICENSURE RENEWAL TO PROVIDE SERVICES TO ADULTS WITH DEVELOPMENTAL DISABILITIES OR APPLICATION TO ADD A SERVICE OR ADD A SITE

DATE_____

License #:_____

APPLICATION FOR: Renewal of License:_____**Add a Service:**_____**Add a Site:**____

Applicant Information: Identify the person, partnership, corporation, association, or governmental agency applying to lawfully establish, conduct, and provide services:

Name of Organization:_____

Mailing Address:_____

City:_____ State:_____ Zip Code:_____

Telephone:_____ Fax:_____ FEIN:_____

Chief Executive Officer or Director: Identify the person responsible for the overall management and oversight of the service(s) to be operated by the applicant:

Name:_____ Title:_____

Telephone:_____ Fax:_____ Email Address:_____

Website (if applicable):_____

Organizational Structure

Type of Ownership: (Check One): Individual _____ Partnership _____ Corporation _____

Other (Specify) _____

Check One: For Profit _____ Non-Profit _____

Is the Organization Incorporated: Yes _____No _____ Date of Incorporation: _____

Do you have a Board of Directors? Yes _____No _____

If yes, attach a current list of the Board of Directors which includes the address, title, and term of office for each member.

If no, attach a current list of the members of the Advisory Board which includes the address, title, and term of office for each member.

Is the organization licensed, certified or accredited by any other authority? Yes ___ No _____

If yes, list authority and type of license, accreditation or certification:_____

Has any application for a license, certification or accreditation ever been denied? Yes ___ No _____

If yes, explain:_____

I. Services Information: Use the list below and check the services that you are requesting licensure for.

1. Residential Supports Services
   - A) _____ Community Residence Support Service
   - B) _____ Non-congregant Residential Support Service
   - C) _____ Shared Living Arrangement Service
2. Day Program Services
   - A) _____ Center Based Day Program Service
   - B) _____ Community Based Day Program Service
   - C) _____ Supported Employment Services
3. Fiscal Intermediary Services _____
4. Community Based Supports Services _____

Name of Facility/Program:_____

Address:_____

Name of Contact Person:_____ Title:_____

Telephone Number:_____Fax Number:_____

Proposed Opening Date (if New):_____

Service Type:_____

(If Community Residence) Bed Capacity: _____

(If Center Based Day Program) Total Capacity: _____ Is this a sheltered workshop? Yes___ No ____

Name and Address of Owner: _____

Type of Building(s): Apartment___ Condominium___ Single Family___ Duplex___ Multi-Family____ Other _____

Type of Zoning: _____

Does building have a fire sprinkler system? Yes _____ No _____

Is building fire alarm connected to local fire department? Yes _____ No _____

Date of last **State Fire Marshal Inspection**: _____ Attach a copy of **current** SFM Inspection Report.

If rented or leased, is owner willing to allow any necessary repairs or renovations to be made to the building to meet necessary life-safety requirements? Yes _____ No _____

If No, what is your alternative plan?_____

Does the building comply with all applicable federal, state and local laws, codes, rules and regulations relative to health, accessibility, fire safety, building, minimal housing and zoning? Yes _____ No _____

Is facility or program licensed, certified or accredited by any other authority? Yes ____ No____

If yes, by what authority and list types of license, accreditation or certification?_____

Has any application for a license, certification or accreditation for this facility or program ever been refused?

Yes_____ No _____

If yes, explain:_____

For Residential Supports Services that are not provided in Community Residences, but that are provided in either Non-Congregant Settings or Shared Living Arrangements, please attach a listing of all of those sites. Please include the address of the site, the type of Residential Supports Services provided at the site (i.e. - Non-Congregant Residential Support Service or Shared Living Arrangement Service), and the name(s) of the supported participant(s) at the site.

NARRATIVE

Please describe any changes in your program since your last application.

Please describe any changes of the organization's owners and/or officers, and any changes in the organizational structure since your last application.

FINANCIAL

Describe the proposed financial plan.

Describe funding sources and amount funded by each source. Include any fees charged to participants.

Current budget.

List accountant and date of last audit.

Additional Information

* I am aware that the Department may require additional financial indicators that are necessary to establish that the applicant/licensee is in good financial standing.
* I am aware that authorized representatives of the Licensing Agency have the right to enter without prior notice to inspect the entire premises and services, including all records of any facility for which an application has been received or for which a license has been issued. This application shall constitute permission for and willingness to comply with such inspections.
* I am aware of the statutory authority of the Department as contained in chapter 40.1 of the Rhode Island General Laws, and of the standards, rules and regulations prescribed therein, which regulate the operation of facilities and programs that provide services to adults with developmental disabilities.

TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL INFORMATION CONTAINED HEREIN IS CORRECT AND COMPLETE. I FURTHER DECLARE MY AUTHORITY AND RESPONSIBILITY TO MAKE THIS APPLICATION.

Signature of Applicant:_____ Date:_____

Name of Applicant (print): _____ Title:_____

If you have any questions concerning the application, please contact this office at (401) 462-6049.

This application shall be returned before the end of the current licensure period to:

ADMINISTRATOR OF LICENSING
OFFICE OF FACILITIES AND PROGRAM STANDARDS AND LICENSURE
DEPARTMENT OF BEHAVIORAL HEALTHCARE, DEVELOPMENTAL DISABILITIES AND HOSPITALS
14 HARRINGTON ROAD, BARRY HALL
CRANSTON, RHODE ISLAND 02920

Revised: 6/13/13

ASSURANCE OF COMPLIANCE WITH THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE REGULATION UNDER TITLE VI OF THE CIVIL RIGHTS ACT OF 1964

_____ (hereinafter called the "applicant")
(Name of Applicant)

HEREBY AGREES THAT it will comply with title VI of the Civil Rights Act of 1964 (P.L. 88-352) and all requirements imposed by or pursuant to the Regulation of the Department of Health, Education, and Welfare (45 CFR Part 80) issued pursuant to that title, to the end that, in accordance with title VI of that Act and the Regulation, no person in the United Stated shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department; and HEREBY GIVES ASSURANCE THAT it will immediately take any measures necessary to effectuate this agreement.

If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. In all other cases, this assurance shall obligate the Applicant for the period during which the Federal financial assistance is extended to it by the Department.

THAT ASSURANCE is given in consideration of and for the purpose of obtaining any and all Federal grants, loans, contracts, property, discounts or other Federal financial assistance extended after the date hereof to the Applicant by the Department, including installment payments after such date on account of applications for Federal financial assistance which were approved before such date. The Applicant recognizes and agrees that such Federal financial assistance will be extended in reliance on the representations and agreements made in this assurance, and that the United States shall have the right to seek judicial enforcement of this assurance. This assurance is binding on the Applicant, its successors, transferees, and assignees, and the person or persons whose signatures appear below are authorized to sign this assurance on behalf of the Applicant.

_____

Signature of Applicant:_____ Date:_____

Name of Applicant (print): _____ Title:_____

_____

_____
Applicant's mailing address:

Revised: 6/13/13

Department of Behavioral Healthcare, Developmental Disabilities and Hospitals
Facilities and Program Standards and Licensure

ADDENDUM TO LICENSE APPLICATION

License Number:_____

Verification of Federal Employer Identification Number and affidavit concerning taxpayer status.

Pursuant to Chapter 75 of Title 5 of the Rhode Island General Laws, as amended, any person applying for or renewing any license, permit, or other authority to conduct a business or occupation within Rhode Island must have filed all required state tax returns and paid all taxes due to the state or must have entered into a written installment agreement to pay delinquent state taxes that is satisfactory to the Tax Administrator.

I hereby declare, under penalty of perjury, that I have filed all required state tax returns and have either paid all taxes due the state or have entered into a written installment agreement with the Rhode Island Division of Taxation.

_____
Name (Please Print)

_____ _____ _____
Signature Date Federal Employer Identification Number (FEIN)

Furnishing the FEIN is mandatory. The FEIN will be transmitted to the Rhode Island Division of Taxation pursuant to Chapter 75 of Title 5 of the Rhode Island General Laws, as amended.

This form MUST be completed, signed and attached to your license application in order for us to process your application.

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